

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 723

CERTIFICATE OF DEATH

05094

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard
 City or town Farmersville
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 82 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Howard
 City or town Farmersville
(If outside city or town limits, write RURAL and give nearest town)
 Street No. Westerloo Road
(If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Edward Adams

3. (b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sarah E. Adams 6. (c) If alive, give age 75 years
 7. Birth date of deceased (mo., day, yr.) May 7, 1863
 8. AGE: Years 82 Months — Days 17 If less than one day — hrs. — min.
 9. Birthplace Howard Co. Md.
(Town, county, and state)
 10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Edward Adams
 13. Birthplace Maryland
 MOTHER 14. Maiden name Louisa ?
 15. Birthplace Unknown

16. Informant Sarah E. Adams
 Address Ellicott City, Rt 1 Box 126

17. Burial Date thereof May 27, 1945
(Burial, cremation, or removal, Which?) (month) (day) (Year)
 Cemetery or crematory Western Star
 Location Baltimore Co. Md.

18. Funeral director Easton Sons
 Address Ellicott City, Md.

19. May 24, 1945 John B. Laughman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24th 1945, at 9:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5th 1945 to May 24th 1945 and that I last saw him alive on May 24th 1945

Immediate cause of death Mitral Insufficiency
Arterio-sclerosis
 Due to ?
 Due to ?
 Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? — (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —

23. SIGNATURE C. F. Maloney M.D.
 Address Calverville, Ind. Date signed 5/25/45
 M. D. or other —

RECEIVED

MAY 29 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9

CERTIFICATE OF DEATH

05095

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard
 City or town Elcheater
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 mo. 21 days
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Elcheater
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war None

3. (a) FULL NAME

Veronica T. Cugle

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife None
 7. Birth date of deceased (mo., day, yr.) Aug. 6, 1944
 8. AGE: Years 9 Months 21 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Elcheater Howard Co., Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Phillip Cugle
 13. Birthplace Elcheater Md.
 MOTHER 14. Maiden name Margie Deiflinger
 15. Birthplace Virginia

16. Informant Mrs. Margie Deiflinger
 Address Elcheater Md.

17. Burial Date thereof May 29, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Marys Cemetery
 Location Elcheater Md.

18. Funeral director Easton Sons
 Address Ellicott City, Md.

19. May 29, 1945 19 45 John B. Loughman
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1945 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/20 19 45 to 5/27 19 45
 and that I last saw her alive on 5/27 19 45

Immediate cause of death Sabur Pneumonia DURATION 5 days

Due to _____

Due to _____

Other conditions Pertussis 2 weeks

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George Burdorf md M. D. or other _____

Address Ellicott City, Md. Date signed 5/28/45

RECEIVED
JUN 1 1946
BUREAU V.C.

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05096193

1. PLACE OF DEATH:

County..... Howard
City or town..... Poplar Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 50 years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Howard
City or town..... Poplar Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No..... R. F. D. Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

ELIZABETH A. DELAUDER

3. (b) Social Security Number

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Single	
6.(b) Name of husband or wife.....			
7. Birth date of deceased (mo., day, yr.) March 16, 1865			
8. AGE:	Years 80	Months 1	Days 27
6.(c) If alive, give age..... years hrs. min.			

9. Birthplace..... Howard CO. Maryland
(Town, county, and state)
10. Usual occupation..... Housework
11. Industry or business.....
12. Name..... Andrew N. DeLauder
13. Birthplace..... Maryland
14. Maiden name..... Margaret C. Kerrauder
15. Birthplace..... Maryland

16. Informant..... Miss Teresa A. DeLauder
Address..... R.D. Mt. Airy, Md.

17. Burial..... Date thereof..... 5-16-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... St. Michaels Catholic
Location..... Poplar Springs, Howard Co. Md.

18. Funeral director..... C. M. Waltz
Address..... Winfield, Md.

19. 5/16/45- E. Paul Mann
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13, 1945, at 9:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 12, 1945, to May 13, 1945
and that I last saw him alive on May 12, 1945

Immediate cause of death..... Cerebral Hemorrhage
DURATION..... 15 hrs.

Due to..... Arterio Sclerosis
Due to..... Age -

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... C. M. Waltz
M. D. or other
Address..... Mt. Airy Md. Date signed..... 5-13-45

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

MEMORANDUM FOR THE ATTORNEY GENERAL

RECEIVED
JUN 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

CERTIFICATE OF DEATH

05097

9

Reg. Dist. No.

1. PLACE OF DEATH:

County Howard
City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: Life
How long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Howard
City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1944 Furnace Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Christina A Ege

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Late John F. Ege

7. Birth date of deceased (mo., day, yr.) Nov 10, 1860

8. AGE: Years 84 Months 6 Days 1 If less than one day
.....hrs.min.

9. Birthplace Elkridge, Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

12. Name Ludwig Thurnau

13. Birthplace Prussia

14. Maiden name Anna Vetter

15. Birthplace Prussia

16. Informant Mrs. Marie Carey

Address 1944 Furnace Rd., Elkridge, Md

17. Natural Date thereof 5/14/45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Belleville M. E. Cem.

Location Elkridge, Md

18. Funeral director John J. Bowman & Son

Address 901-03 Hollins Street

19. 5/14/45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 15 to May 11 19 45

and that I last saw him alive on May 9 19 45

Immediate cause of death Carcinoma uterus

Due to ?

Due to ?

Other conditions Metastasis to spine

(Include pregnancy within 8 months of death)

Major findings of operations Complete removal by radium

Antopsy results Complete removal by radium

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. Edward Butler

Address Medical Arts Bldg.

Date signed May 12 1945

MARGIN RESERVED FOR BINDING

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

05098

1. PLACE OF DEATH:

County.....Howard

City or town.....Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....2.3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Howard

City or town.....Ellicott City
(If outside city or town limits, write RURAL and give nearest town)Street No.....Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....None

3. (a) FULL NAME

Rachel Larther

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Lloyd Thomas
Larther

7. Birth date of

deceased (mo., day, yr.)

Dec. 22, 1921

8. AGE:

Years

Months

Days

If less than one day

23

4

30

hrs.

min.

9. Birthplace

Ellicott City, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Marcellus Hammond

13. Birthplace

Ellicott City, Md.

MOTHER

14. Maiden name

Arlene A. Fuller

15. Birthplace

Ellicott City, Md.

16. Informant

Lloyd T. Larther

Address

Ellicott City, Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

May 25, 1945

Cemetery or crematory

Fuller Family

Location

Pine Orchard

18. Funeral director

Eaton Sons

Address

Ellicott City, Md.

19. Date rec'd by registrar

May 23, 1945

1945

John B. Loughran

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 21st.....1945.....at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-16-45.....19.....to 5-16-1945

and that I last saw him alive on 5-21-45.....19.....

Immediate cause of death

DURATION

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

C. J. Malone, MD

M. D. or other

Address

57 Winters Lane

Date signed 5/22/46

Calverville - 28. Md

RECEIVED
MAY 25 1945
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24193

1. PLACE OF DEATH:

County Howard

City or town Elkwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Howard

City or town Elkwood
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Walter Charles Hammond

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Hattie M. Mathews

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1858 6.(c) If alive, give age _____ years

8. AGE: Years 86 Months 8 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace MD.
(Town, county, and state)

10. Usual occupation Farm

11. Industry or business _____

12. Name Nicholas W. Hammond

13. Birthplace MD.

14. Maiden name Mary Ellen Wood

15. Birthplace MD.

16. Informant Mrs. Mildred Wilson

Address 105 Newburg Ave. Catonsville, MD

17. Burial, cremation, or removal, Which? Burial Date thereof May 30, 1945
(month) (day) (year)

Cemetery or crematory Oak Grove Cemetery

Location Elkwood, MD

18. Funeral director C. Harry Wynn

Address Hydenville, MD

19. May 28 19 45 C. Harry Wynn
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 19 45 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1929 19 _____ to May 27 19 45

and that I last saw him alive on May 26 19 45

Immediate cause of death Coronary Thrombosis DURATION 2 days

Due to Coronary arterio-sclerosis 6 mos.

Due to General Arterio-Sclerosis ? yrs

Other conditions Chr. Hypertension ? yrs
Chr. Nephritis ? yrs
(Include pregnancy within 8 months of death)

Major findings of operations none Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Stanley Grubill M. D. or other _____

Address Maryland Date signed 5/27/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

JUN 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4637

CERTIFICATE OF DEATH

05100

Reg. Diat. No. 191

1. PLACE OF DEATH:

County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)Street No. Rogers Ave
(If Rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rhoda Agnes Harless

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

w

6.(a) Single, married, widowed, or divorced

married

B.(b) Name of husband or wife

E. C. Harless

7. Birth date of

deceased (mo., day, yr.)

May 1, 1886

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

59017

hrs.

min.

9. Birthplace

Mathias, W.Va.
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

Lorenza W. Shupe

13. Birthplace

W.Va

MOTHER

14. Maiden name

undisclosed

15. Birthplace

"

16. Informant

Paul Harless

Address

Ellicott City Md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

5-22-45
(month) (day) (year)

Cemetery or crematory

St Johns

Location

Ellicott City Md

18. Funeral director

F C Higginbotham

Address

Ellicott City Md

19.

May 22
(Date rec'd by registrar)

19. 45

John B. Loughran
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 45, at 11 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 1 19 45, to May 19 19 45
and that I last saw h. alive on May 19 19 45

Immediate cause of death

carcinoma of head of
parotid

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edna L. Luman, M.D.

M. D. or other

Address Ellicott City Md Date signed 5/19/45

RECEIVED
MAY 25 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05101 190
Reg. Dist. No.

1. PLACE OF DEATH:

County Howard
 City or town Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Elkridge (27)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1945 Railroad ave
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Mary Parsey Horsey

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife William S. Horsey
 6. (c) If alive, give age 74 years
 7. Birth date of deceased (mo., day, yr.) Dec 22, 1884
 8. AGE: Years 60 Months 5 Days 6 If less than one day
hrs.min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Dowling
 13. Birthplace Ireland

MOTHER 14. Maiden name Mary Allen
 15. Birthplace Baltimore, Md.

16. Informant Mr William S. Horsey
 Address 1945 Railroad Ave Elkridge Md.

17. Burial Date thereof May 30, 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Melville Cemetery
 Location Elkridge (27) Md.

16. Funeral director L. Lester Corp
 Address 5503 Main St. Elkridge (27) Md.

19. May 28 19 45 (miss) E. Bird Williams
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27-45 at 10:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/27-1945 to 5/27-1945
 and that I last saw her alive on no date 19 45

Immediate cause of death Hypertensive Cardio-Vascular Disease
Death Central Hemorrhage

DURATION

2 yr.Instant

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George E. Buehler MD

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY or other

Address Elkridge Md. Date signed 5/27/45

RECEIVED
MAY 19 1966
TUBERHILL T.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 636

CERTIFICATE OF DEATH

T 05102 194 239
Reg. Dist. No.

1. PLACE OF DEATH: Howard
County Fulton (Rural)
City or town (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Fulton (Rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Highland Rd.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Herrman Kalfach

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Grace Elizabeth Kalfach
6. (c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) May 10, 1874
8. AGE: Years 71 Months 16 Days 16 If less than one day hrs. min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business General producer

12. Name Fredrick Kalfach

13. Birthplace Germany

14. Maiden name Wilhelmina Rex

15. Birthplace Germany

16. Informant Tom Sean E. Kalfach

Address Fulton Md.

17. Burial Date thereof May 30-45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Pauls

Location Fulton Md.

18. Funeral director Lloyd Kaiser

Address Laurel Md.

19. May 30 19 45 Con E. Wachtel
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19 45, at 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 40 May 26 19 45
and that I last saw him alive on May 26 19 45

Immediate cause of death Cerebral hemorrhage
DURATION 5 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert S. H. Jones M. D. or other

Address 402 Main St. Laurel Md. Date signed 5/26/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

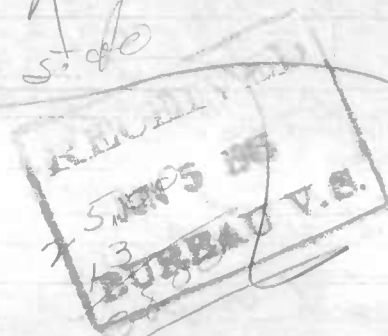
PHYSICIAN

Please underline the cause to which death should be charged statistically.

Cecil Olive & Phillip
Hester Lester & Dean

~~Husband~~
~~Wife~~
~~Child~~

Anna & Lill
Raymond
5.00



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

05103

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **Howard**City or town..... **Marroitsville**
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... **5 wks.**

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Md. Balto.** County..... **Baltimore**City or town..... **Halethorpe**
(If outside city or town limits, write RURAL and give nearest town)Street No..... **4610 Linden Ave.**
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Nora McKentley

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Female**Wht.****Widow**6. (b) Name of husband or wife..... **Augustus McKentley**

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... **April 25, 1860**8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.
85..... **20**.....9. Birthplace..... **Berks Co. Penna.**
(Town, county, and state)10. Usual occupation..... **House-wife**

11. Industry or business.....

12. Name..... **Solomon High**13. Birthplace..... **Penna.**14. Maiden name..... **Amelia Hoch**15. Birthplace..... **Penna.**16. Informant..... **Charles E. Oyler**Address..... **1248 Greyston Rd.
Halethorpe 27 Md.**17. **Burial** Date thereof..... **May 16, 1945**
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... **Alsace**Location..... **Reading Penna.**18. Funeral director..... **Robert S. Little**Address..... **2700 Edmondson Ave.**19. **5/16** 19 **45** **Amelia Hoch**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... **5/15** 19 **45** at **8:20 P.** M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **5/10** 19 **45**, to **5/15** 19 **45** and that I last saw him alive on **5/15** 19 **45**Immediate cause of death..... **Arteriosclerosis**

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Signature..... **W. H. Barnes MD**

M. D. or other

Address..... **By Knoxville Md** Date signed..... **5/16/45**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County... Howard
 City or town... Rogers Ave. Elliecott City, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 15 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Howard
 City or town... Elliecott City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Rogers Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Sylvester Miller

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

B. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

Dec. 10, 1874

8. AGE:

Years

70

Months

4

Days

24

If less than one day

...hrs. ...min.

9. Birthplace

Marysville Howard Co.
 (Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Hessy Miller

13. Birthplace

MOTHER

14. Maiden name

Mary E. Russell

15. Birthplace

16. Informant

Mrs. Russell M. Miller

Address

Elliecott City, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 7, 1945
 (month) (day) (year)

Cemetery or crematory

Good Shepherd Cem.

Location

Elliecott City, Md.

18. Funeral director

Eaton Sons

Address

Elliecott City, Md.

19. May 7

(Date reg'd by Registrar)

19 45

John B. Loughran
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 4, 1945 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1945 to May 4, 1945
 and that I last saw him alive on 5/4 1945

Immediate cause of death

Arteriosclerotic Cardio-vascular Disease

DURATION

1 yr.

Due to

Due to

Other conditions

none

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Burdick
Elliecott City, Md.
 Date signed 5/4/45

RECEIVED

MAY 9 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 632

CERTIFICATE OF DEATH

Reg. Dist. No. 199

1. PLACE OF DEATH: Howard
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland Howard
 State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. Woodbine
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME EDNA MULLINIX

3. (b) Social Security Number

4. Sex Female 5. Color of face White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Harrison E. Mullinix

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1894 6. (c) If alive, give age 56 years

8. AGE: Years 50 Months 5 Days 23 If less than one dayhrs.min.

9. Birthplace Howard Co. Maryland
 (Town, county, and state)
 Housewife

10. Usual occupation.....

11. Industry or business.....

12. Name William H. Hobbs

13. Birthplace Maryland

14. Maiden name Ida B. Bazzell

15. Birthplace Maryland

16. Informant Mr. Harrison E. Mullinix

Address Woodbine, Md.

17. Burial Date thereof 5-19-45
 (Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Oak Grove

Location Glenwood, Howard Co. Md.

18. Funeral director C. M. Waltz

Address Winfield, Md.

19. May 19 45- E. Paul McCain Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945 at 12:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1941 to May 17 1945 and that I last saw her alive on May 16, 1945

Immediate cause of death Coronary Thrombosis DURATION 2 days

Due to Chr. Myocarditis 5 yrs

Due to.....

Other conditions Thyroid Toxicosis 3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other

Address Exbury, Md. Date signed 5/17/45

RECEIVED
JUN 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

193

1. PLACE OF DEATH:

County..... Howard
 City or town..... Poplar Springs
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 52 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Howard
 City or town..... Poplar Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... R. D. Woodbine
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

STEPHEN OLIVER PICKETT

3. (b) Social Security Number

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Lilly M. Pickett
 6.(c) If alive, give age..... 73 years
 7. Birth date of deceased (mo., day, yr.)..... March 26, 1870
 8. AGE: Years..... 75 Months..... 1 Days..... 15 If less than one day..... hrs. min.

9. Birthplace..... Howard CO. Maryland
 (Town, county, and state)
 10. Usual occupation..... Farmer
 11. Industry or business.....

FATHER 12. Name..... William W. Pickett
 13. Birthplace..... Maryland
 MOTHER 14. Maiden name..... Amanda V. Bowman
 15. Birthplace..... Maryland

16. Informant..... Mrs. Lilly M. Pickett
 Address..... Woodbine, Md.

17. Burial Date thereof..... 5-14-45
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory..... St. Michael's Catholic
 Location..... Poplar Springs, Howard Co. Md.
 C. M. Waltz

18. Funeral director.....
 Address..... Winfield, Md.

19. 5/12/45 46- E. Pearl Manner Registrar
 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 11, 1945 19..... at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Sept., 1944 19..... to May 11, 1945
 and that I last saw him alive on May 11, 1945 19.....

Immediate cause of death..... Cerebral Hemorrhage
 DURATION..... 2 days

Due to..... Aterio-sclerosis ? yrs

Due to..... Chr. Hypertension ? yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... none

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. Stanley Grabill M. D. or other

Address..... Mt. Airy, Md. Date signed 5-11/45

MINISTRY OF DEFENSE

CERTIFICATE OF SERVICE

RECEIVED

JUN 5 1945

BUREAU V.P.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

75106

1. PLACE OF DEATH

County Howard Registration Dist. No. 198
 Village or City near Morgan No. 1226 St. Ward
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

Charles Rallins If U. S. Veteran, specify WAR
 (a) Residence: No. St. Ward.
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>	
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>single</u>			
6. DATE OF BIRTH (month, day, and year) <u>march 11 1890</u>			
7. AGE <u>55</u>	Years <u>51</u>	Months <u>10</u>	Days <u>26</u>
		If LESS than 1 day, <u> </u> hrs. or <u> </u> min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Laborer</u>		
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>Farm</u>		
	10. Date deceased last worked at this occupation (month and year) <u>May 2</u>		
		11. Total time (years) spent in this occupation <u>Life</u>	
MOTHER FATHER	12. BIRTHPLACE (city or town) <u>Howard Co Md</u> (State or country)		
	13. NAME <u>Frank Rallins</u>		
	14. BIRTHPLACE (city or town) <u>Howard Co Md</u> (State or country)		
	15. MAIÖEN NAME <u>Betty White</u>		
16. BIRTHPLACE (city or town) <u>Howard Co Md</u> (State or country)			

17. INFORMANT John White
(Address) Woodbine
 18. BURIAL, CREMATION, OR REMOVAL
Place Bush Park Date May 10, 1945
 19. UNOERTAKER H. M. Snyder
(Address) Mt. Airy
 20. FILED May 10, 19 45 Paul Martin
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

May 7, 1945
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

May 5, 1945, to May 7, 1945

I last saw him alive on May 6, 1945; death is said

to have occurred on the date stated above, at 11:30 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Intestinal Stasis
(Blocked Bowels)
Underlying Cancer unknown
Not due to cancer or acute condition.

Date of onset

Apr 30

Other Contributory Causes of Importance:

Intestinal Toxemia

Name of operation Physical Examine Date of What test confirmed diagnosis Physical Examine Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury , 19 Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury Nature of Injury 24. Was disease or injury in any way related to occupation of deceased? noIf so, specify (Signed) C. M. Van Rader M. D.(Address) Mt. Airy Md

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:

County Howard CountyCity or town Jessups Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

New Yorker Inn Jessups Md

How long in hospital or institution?

3. (a) FULL NAME

George J. Schilling

4. Sex

Male

5. Color or race

White

6. (d) Single, married, widowed, or divorced

Widower

8. (b) Name of husband or wife

Constance Schilling

7. Birth date of

deceased (mo., day, yr.)

Aug 14 - 1882

6. (c) If alive, give age years

8. AGE:

Years 62 Months - Days - If less than one day

hrs. min.

9. Birthplace

Bethesda, Md

(Town, county, and state)

10. Usual occupation

Retired Shipbuilder

11. Industry or business

Both-Fairfield S. Gard

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mr. Henry Sanders

Address

Jessups Md

17. (Burial, cremation, or removal, Which?)

CremialDate thereof May 31 - 45

Cemetery or crematory

Parkwood Cemetery

Location

Baltimore Md

18. Funeral director

Milton Schilling

Address

3914 S Hanover St (25)

19. (Date rec'd by registrar)

May 29 1945

Ida M. Whelan

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Howard CountyCity or town Jessups Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Washington Blvd

(If rural, give LOCATION)

2. (d) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28th 19 45 at 6:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28th 19 45 to May 28th 19 45and that I last saw him alive on May 28th 19 45

Immediate cause of death

Pulmonary I.B.

DURATION

2 wks.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Shipley, M.D.

M. D. or

Address Savage, Md. Date signed 5/28/45

RECEIVED
JUN 4 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

05108
190

Reg. Dist. No.

1. PLACE OF DEATH:

County Howard

City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs

Hospital, institution, or street address where death occurred:

6110 old Wash Blvd.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Howard

City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6110 old Wash Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME

John Frederick Summers

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Clara Mae Royal
Summers 6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 26 1949

8. AGE: Years 8 Months 3 Days 0 If less than one day — hrs. — min.

9. Birthplace Baltimore City MD
(Town, county, and state)

10. Usual occupation R.R. Foreman

11. Industry or business Railroad

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Mr. General E. Summers (son)

Address 6110 old Wash Rd. Elkridge, MD

17. Burial Date thereof 5/29/49
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Western

Location Edmondson Ave & Longwood St.

18. Funeral director Harry N. Witzke

Address 4101 Edmondson Ave

19. 5/29 49 MD HW. Rebeck
(Date see'd by registrar) (State) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1949 at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to May 26 1949

and that I last saw him alive on May 25 1949

Immediate cause of death Chronic Myocarditis 1 yr.

& Decompensation 2 mo

Due to General arterio 10 yrs

sclerosis 10 yrs

Due to Senility 10 yrs

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE B.B. Brumbaugh M. D. or other

Address Elkridge, MD Date signed 5/26/49

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
year of birth of deceased
is shown on

FILM No. G 96 JUN 29 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B7C

CERTIFICATE OF DEATH

05109
195
Reg. Dist. No.

1. PLACE OF DEATH:

County Howard

City or town Green Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lucie Anna Souder

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White m

6. (b) Name of husband or wife Harold H. Souder

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1889 (2) 1878

8. AGE: Years 66 Months 9 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Howard County
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name George F. Fiddings Sr.

13. Birthplace Maryland

14. Maiden name John Anna Cross

15. Birthplace Maryland

16. Informant Harold H. Souder

Address Laurel, Maryland R.F.D.

17. Burial Date thereof May 31, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Emmanuel Cemetery

Location Scaggsville, Howard Co. Md.

18. Funeral director W. H. H. Donaldson

Address Laurel, Maryland

19. SP 30/45 Frank Shipley
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Green Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (d) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945 at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 1935 to May 28 1945

and that I last saw her alive on May 28 1945

Immediate cause of death Acute Cor. Arteriosclerotic

Myocarditis 10 yrs

Due to Arteriosclerosis

Due to Chr. Nephritis

Other conditions Generalized

Arteriosclerosis
(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Warren M.D.

Address Laurel, Md. Date signed 5/30/45

RECEIVED

JUN 5 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH:

County... Howard

City or town... Potosi Springs
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Howard

City or town... Potosi Springs
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eddie Thompson

3. (b) Social Security Number

H

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Theodore C. Thompson

7. Birth date of

deceased (mo., day, yr.)

April 24, 1868

8.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

77

1

5

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

Home

FATHER

12. Name

Cedric B. Duwall

13. Birthplace

Md.

MOTHER

14. Maiden name

Sarah King

15. Birthplace

Md.

16. Informant

Mr. Fred Thompson

Address

Mt. Airy, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Mt. View Cemetery

Location

Howard Co., Md.

18. Funeral director

C. Harry Zuer

Address

Lynchville, Md.

19.

Date rec'd by registrar

June 1, 1945

1945

E. Pearl McNeill

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 29

1945 at 10:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1945

to May 29 1945

and that I last saw her alive on

May 29 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

24 hrs

Due to

Carcinoma of

stomach with general

metastasis

Due to

Diabetes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. M. Van Hook

M. D. or other

Address

Mt. Airy, Md.

Date signed

5/30/45

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUN 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Howard
City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
1920 Furnace ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Howard
City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1920 Furnace ave
(If rural, give LOCATION)
2.(a) If veteran, name war na

3. (a) FULL NAME

Joseph Henry Toomey 2nd

3. (b) Social Security Number

218-07-5720

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ethel May Carroll Toomey

7. Birth date of deceased (mo., day, yr.) Oct 17 - 1987

8. AGE: Years 37 Months 7 Days 16 If less than one day hrs. min.

9. Birthplace Elkridge Md
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Various

12. Name Joseph Henry Toomey

13. Birthplace Baltimore, Maryland Md

14. Maiden name Barbara Schucke

15. Birthplace Hamover Md

16. Informant Lewis C. Toomey (Bro)

Address 2510 Furnace ave, Elkridge

17. burial Date thereof 6/1/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Frydons Port Lane

Location 3801 Frederick Ave

18. Funeral director John Bowman & Son

Address 901-03 Hollus St

19. 5/31 45 Hatt
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1948 at 9:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to May 29 1945 and that I last saw him alive on May 29 1945

Immediate cause of death.....

Ch. Myocarditis 3 yrs

Ch. Myocarditis 1 yr

Due to Ch. Myocarditis 2 yrs

Arterial Hypertension 4 yrs

Due to General arteriosclerosis 7

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. none

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE B. B. Brown M. D. or other

Address 3809 Main St

Date signed 5/29/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

CERTIFICATE OF DEATH

Reg. Diat. No. 191113

1. PLACE OF DEATH:

County HowardCity or town Cashville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Cashville
(If outside city or town limits, write RURAL and give nearest town)Street No. Glenwood Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rachel Augustus Warfield

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Alex Warfield

7. Birth date of

deceased (mo., day, yr.)

Dec. 13, 1880

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

6451

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

Humphrey Henry

13. Birthplace

md

MOTHER

14. Maiden name

Kate Rogers

15. Birthplace

md

16. Informant

Alex Warfield

Address

Glenwood md

17.

(Burial, cremation, or removal, Which?)

Date thereof

5-17-1945

(month) (day) (year)

Cemetery or crematory

oak Grove

Location

Glenwood md.

18. Funeral director

J.C. McWhorter

Address

Elkton City md

19.

(Date rec'd by registrar)

May 17 1945John B. Loughran
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945 at 4 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1944 to May 1945
and that I last saw him alive on May 14 1945

Immediate cause of death

Cancer of the Pancreas

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J.H. Barnes MD
Address By Kenneth M. Jones Date signed May 17 1945

RECEIVED
JUN 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13120

CERTIFICATE OF DEATH

Reg. Dist. No. 105113 195

1. PLACE OF DEATH:

County HowardCity or town Savage
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 1/2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. Sturford Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Catherine Welsh

3. (b) Social Security Number

none4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife Milton W. Welsh7. Birth date of deceased (mo., day, yr.) Jan 27 1865 6. (c) If alive, give age _____ years8. AGE: Years 80 Months 3 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Woodlawn, Howard Co Md
(Town, county, and state)10. Usual occupation Domestic11. Industry or business Retired12. Name Lance Fat Hobbs13. Birthplace Howard Co Md14. Maiden name Matilda Warsfield15. Birthplace Howard Co Md16. Informant Mrs Blanche WelshAddress Savage Md17. Burial Date thereof May 17-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Savage MdLocation Savage Md18. Funeral director Lloyd KauerAddress Lynch Md19. 5/16/45 19. Thanksgiving
(Date rec'd by registrar) (month) (day) (year) Registrar Per S. W.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945 at 1:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1944 to May 14 1945and that I last saw him alive on May 14 1945Immediate cause of death Ch. Myocarditis DURATION 1 yrCh. MyocarditisDue to General arteriosclerosisDue to SclerosisOther conditions Serumity

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury Dr. Ferant's Shop Injured at work? _____23. SIGNATURE Dr. Ferant's Shop M. D. or other _____Address 5714/45 Date signed _____

RECEIVED
JUN 5 1945
BUREAU V.E.